

THE CHIRONIAN.

VOL. XXVII

OCTOBER, 1910

No. 4

TRANSPLANTATION OF THE CORNEA.

The Preliminary Report of a Single Case.

Royal S. Copeland, A. M., M. D., Professor of Ophthalmology.

In the literature, so far as I have discovered, are a half dozen brief references to the subject of keratoplasty. To my mind the most satisfactory of these is in Vol. III., of Norris and Oliver's "System of Diseases of the Eye" (1898), and is from the pen of my good old friend, Dr. Herman Knapp. He follows Czermak's book, "The Ophthalmic Operations" (1896), apparently, and after translating a brief excerpt from this author, with a hasty reference to Professor von Hippel, whose work in this line is described as "less successful than the others," Dr. Knapp dismisses the subject as one little heard of since 1888, and hints that it is an operation which never "would go out of the laboratory into the practice of ophthalmology."

Professor von Hippel's work, so far as I know, has been entirely with rabbits, or, at least, with the eyes of the lower animals. Ball's recent book on Ophthalmology (1908) speaks of Fuchs' use of enucleated human eyes as a source of the transparent corneal tissue and says that two surgeons work simultaneously, one removing the leucomatous tissue and the other taking out the eye, from which, after enucleation, the tissue is removed. My own reading of Fuchs has led me to believe the Vienna operator makes use of this procedure to separate an adherent and resistive iris, and that it is not intended for optical reasons solely. In his "Text Book of Ophthalmology" (1899), speaking of his non-success in preserving the transparency of transplanted cornea, Fuchs says: "The object that the operation was intended to subserve is, nevertheless, obtained in that the staphyloma is replaced by a flat cicatrix not adherent to the iris."

Fick, of Zurich, speaks of keratoplasty as "an operation of the future." He is not satisfied with his own experiments, in which he used animal tissue, but speaks of the good results of Kuhnt in a single case.

Swanzy, of Dublin, in 1903, mentions von Hippel's work in transferring rabbits' tissue to the human cornea and states that "twenty months afterwards the flap continued transparent" with satisfactory vision.

Prof. de Schweinitz, in these words, voices the usual sentiment: "The method does not seem likely to meet with sufficient success to warrant its adoption." In this country it seems not to have been attempted at all. Indeed, the almost complete failure of the profession generally to follow the pioneers in this matter, and the sensational reception of what this writer at the time considered a commonplace thing, have convinced him that here is a field worthy of more tilling than has yet been given it. He is amazed that such interest should attach to this attempt to give a poor blind chap enough vision to get about, and has been greatly embarrassed that the case, knowledge of which accidentally escaped, has seemed, by its very novelty, to possess news value of unusual proportions. To the end that the profession may take the full measure of the merits or demerits of the operation, adopting whatever is worth while, and may not be misled into thinking that all the blind may be made to see, this early report is made. It must, of course, be subject to conclusions which time alone may determine to be lasting, and, under other circumstances, would not be presented to the profession until more thoroughly seasoned.

My patient was a Chinaman, male, aged 26. Some time ago a suppurative keratitis, involving practically the entire cornea of each eye, destroyed the transparency of that tissue and left it a dense, leucomatous, useless membrane. Strong light focussed upon either eye revealed light perception and accurate projection. Not enough even in the way of a rim of good tissue remained to give hope of vision from an iridectomy. Further embarrassment was added by the adherent and contained iris, locked in the scar of a healed corneal perforation, and, in this respect, one eye was as hopeless as the other. The pupil was later found to be occluded.

If the surgeon is ever permitted to experiment and except for experimentation how is the sum total of human knowledge to be in-

creased, here was a case where one must be fully justified in attempting some new thing. A kind Providence brought about a combination of fortuitous circumstances. After sending the man to Flower Hospital, another patient appeared who had injured an eye four years ago and because of an irido-cyclitis, with symptoms of sympathetic irritation, demanded enucleation. We now had the material and needed nothing more than von Hippel's trephine.

Fortunately, one of the instrument houses had just imported one of these ingenious little affairs and without it, or some similar device, transplantation, with hope of perfect adjustment of the flap and continued transparency, would not be bright.

The same preparation of each patient as for cataract extraction was made and both were anesthetized at the same time. All was ready then for operating.

The human cornea varies in thickness from .8 to 1.2 m.m. It was the testimony of one author consulted that a thing to be avoided is the leakage of aqueous into the wound. It was my endeavor, therefore, to prevent this by going no deeper than Descemet's membrane. The von Hippel trephine is made with an adjustable shoulder which acts as a stop. The instrument was accordingly set at three-quarters of a m.m., and the diameter of the blade selected was 5 m.m. At the top of the shaft is a spring like that of a watch; this is released and the blade rapidly rotates so long as the trigger is kept under pressure.

Having used the trephine on the patient's eye and carried it in till the shoulder pressed the corneal surface, the instrument was removed and the flap dissected off. The wisdom of Dr. Knapp's suggestion was at once apparent. In the article previously quoted he said the operation was less indicated if the opacity occupies the entire thickness of the corneal substance. In passing, I may say that the immediate satisfactory result of the operation was interfered with by the cloudiness of Descemet's membrane. However, I scraped away as much of the uncut deeper tissues as I dared and, except for the well known resistance and elasticity of Descemet's membrane, must have ruptured that layer. No aqueous escaped, and that patient was left while the other was given attention.

In the eye which had to be enucleated there was no occasion for similar care. The shoulder was removed from the trephine and the blade was sent spinning through the entire thickness of the cornea

and into the anterior chamber. The disc of clear cornea was tenderly transferred to the first patient and gently stroked into accurate apposition. No application whatever was made, but the lids were carefully closed, a pad applied, and the eye bandaged. The enucleation was then made and the patients sent to their respective wards.

At this writing, three months after the operation, the graft remains as clear as when it was first placed in position. The surface is lustrous and the transplanted tissue perfectly transparent. The original Descemet's membrane continues somewhat translucent. A few days ago, in order to provide a pupil, I made an iridectomy, or, what is technically described by Knapp, as an "irido-cystectomy," and by Baird as an "irito-ectomy." In their operation, as is well known, the keratome travels across the anterior chamber to a point beyond the boundaries of the proposed pupil. The knife perforates the iris, Tyrell's hook is inserted and the iris is pulled through the sclero-corneal wound. In performing this operation, my assistants and I were able to see the instruments through the corneal graft, thus demonstrating its transparency. Except for the transplanted corneal disc given my Mongolian patient, his cornea, as I have said, is a mass of scar tissue, and at its periphery there is considerable pannus. It was natural, therefore, that at the time of the iridectomy there should be considerable hæmorrhage from the abnormal corneal vessels, and, following the last operation, an exacerbation of the pannus. Also the iridectomy itself produced a considerable amount of hæmorrhage. This blood in the anterior chamber is not yet sufficiently absorbed to give us an idea of the ultimate visual result of the various operations. However, the patient readily detects the movements of the hand and has prospect of form vision.

I am convinced that corneal transplantation, to paraphrase Knapp, is an operation which deserves to be taken out of the laboratory into the practice of ophthalmology. While this opinion is based upon a single case, unseasoned at that, yet it was a case so unpromising in the beginning, and, so far as the keratoplasty is concerned, looking so favorable at the present time, it encourages me to believe that in selected cases there is every prospect of successful treatment. In a case, for instance, of ophthalmia neonatorum, with serious corneal involvement, or ulcerative keratitis, without perforation, but with a resultant corneal scar which precludes vision and yet which does not extend to Descemet's membrane, kerato-

plasty gives hope of restored vision. The fact must not be overlooked, however, as well pointed out recently by Meller, of Vienna, that any trauma involving Descemet's membrane, such trauma, for instance, as must necessarily be produced in the operation itself, may result in permanent opacity of that membrane.

I do not believe that corneal tissue can be successfully transplanted without the use of some sort of a trephine. Immediate fixation of the graft is essential to transparency. With a trephine, a piece of definite size is removed and this is replaced by a piece of exactly the same size and shape, permitting perfect apposition. There must be as little trauma as possible and as little handling as can be of the tissue to be transplanted. Certainly in selected cases the operation deserves well at the hands of the profession.

58 Central Park, West,

New York City.

Sept., 1910.

THE INFLUENCES OF THE DEEP CERVICAL FASCIA UPON DEEP ABSCESSSES OF THE NECK.*

Ralph I. Lloyd, M. D., Brooklyn, N. Y.

Professor of Anatomy.

The cervical fascia is composed of two layers, the superficial and the deep. The superficial is found just beneath the skin, intimately connected with the platysma. The deep is a more complicated structure. Posteriorly, it is attached in the median line, from above downward, to the external occipital protuberance, lig. nuchae and 7th cervical spinous process. From behind forward, above; it is attached to the protuberance, sup. curved line of the occiput, mastoid process, zygoma and lower jaw. Below from behind forward, spinous process of the 7th cervical, spine of the scapula, acromian process and clavicle.

In the median line anteriorly, it is continuous with layer of opposite side.

If the cross section is made (see illustration), the divisions of the fascia running inward are more easily understood. After leaving the vertebra, it splits to inclose the trapezius; anterior to this, it

*Read before the Homœopathic Medical Society of the County of Kings.

etc., may be traced to the pericardium and is supposed to relieve the heart from pressure during inspiration and expiration, extension of the neck, etc., rendering the pericardium taut through this connection. Abscesses formed in the carotid sheath may extend from the skull above, where pus has entered the skull through the foramen ovale, to the chest below, or even into the axilla as the deep cervical fascia can be traced laterally into the axillary vessels as well as into the chest. Anterior to the sheath it is not so apt to find the chest because the fascia is weak below, anterior to the sterno-mastoid; the pus usually breaking through above the sternum near the median line.

Above, the pus lies external to the pharynx, but does not easily break through the muscular wall, but at the top of the wall where the superior constrictor of the pharynx arches downward to permit the eustachian tube to enter the pharynx, muscle tissue is wanting, the space occupied only by connective tissue. Here pus may enter.

Retro-œsophageal abscesses are of two types, acute or chronic. The former is an infection of retro-œsophageal tissue, but anterior to the prevertebral layer. If the patient lives long enough, it may break into the œsophagus, pus is vomited and recovery may ensue, sometimes very rapidly. The chronic is due to caries of vertebra, is behind the prevertebral layer and must find an exit externally; they point behind the sterno-mastoid as we should expect. As this fascia extends in the mediastinum, either of these types may pass into the chest.

The deep fascia is attached above to the hyoid bone and the superior part extending to the lower jaw splits in two layers, one to the lower border of the jaw and the inner and deeper to the mylo hyoid ridge on the inner surface of the mandible. Posteriorly, these two layers fuse in the stylo maxillary ligament and in the compartment thus formed the submaxillary gland is lodged. The sublingual glands are continuous in the middle line anteriorly and are above the hyoid muscle. Dr. T. Turner Thomas, in the *Annals of Surgery*, February and March, 1908, has shown very clearly that the posterior extremity of the sub-maxillary gland extends inward between the post extremity of the mylo hyoid and the sup. border of the middle constrictor of the pharynx, into the back part of the mouth, at the side of the tongue and there comes in contact with post extremity of the sub-lingual gland. Infections of the connective tissues of these glands will have a serious effect because of the mechanical re-

sults of the swelling on the larynx which is close at hand. This infection is known as Ludwig's angina and in order to avoid misunderstanding let us see what Ludwig considered as diagnostic. In 1836, in the Wurtslemb Arzt Vereins Correspond, he said, "It begins with mild febrile movement, chills, headache, languor and moderate pain on swallowing. Swelling on one or both sides, beginning in the connective tissue of the submaxillary glands, seldom in the parotid or sub-lingual. This hard inflammation spreads, finally occupying the whole lateral and anterior cervical region as high as the chin. The affected area stands out prominently, the tongue rests on a hard, intensely red floor, the part close to the inf. maxillary being converted into a hard ring. Movements of the jaw are hard and difficult. The tongue is forced upward and backward and speech is necessarily hindered, partly due to pressure on the larynx and partly due to stiffness of the muscles. The voice is harsh and guttural. For some time there is no involvement of the skin. For four to six days, the patient is quite comfortable. The moist lymph oozes from the mouth, skin becomes red, spots of softening with crepitation form as if pus had formed but such is not the case. A little later, an opening in the floor of the mouth, laterally or posterior near the root of the tongue or close to the jaw, forms from which stinking grayish or red brown fluid issues. The patient becomes worse, typhoid state develops, deglutition more difficult and death in 10 to 12 days from inception of disease. Post mortem-skin is unimpaired and separated from deeper tissues by serum. The deep tissues are putrefactive, containing gas. No changes in the sub. max. glands themselves." Ludwig called it "Gangrenous Induration of the Neck." The diagnostic points offered by him are as follows: 1. Insignificant inflammation of the oesophagus. 2. Woodlike induration of the swollen tissues which do not pit. 3. Hard swelling in the floor of the mouth with sausage-like induration just inside inf. maxillary. 4. The sharp delineation of the involved tissues, being immediately surrounded by normal tissue.

This disease was known to the ancients, Paulus Aegineta called it *para synanche*. In 1875, Murchison reported an epidemic in the Hebrides and all recovered. Lockwood, of London, has made a careful bacteriological examination of more than a dozen such cases and found the streptococci pyogenes and the staphylococci pyogene, albus in the milder cases; in the more severe, the same germs were

found with either the bacillus of malig. œdema or the bac. aerogenes capsulatus or both. C. J. Aldrich has reported one case after a midwife had cut the fraenum with a dirty brass pin. It has occurred during infectious diseases, such as scarlet fever, diphtheria, typhoid and puerperal fever. It may appear as a sudden œdema of the larynx, from which the patient may recover or take the more severe and longer lasting form as described above. It can be readily seen that the peculiarities are in a great measure due to the anatomical arrangements of the parts. The horseshoe just inside the maxilla is the outline of the two sub-lingual glands with their anterior extremities in contact and the choking and frequent death by asphyxia is due to proximity to larynx of the sub-maxillary gland. As the fascia is dense, the products of inflammation are under pressure.

Case. Mary Pasquale, aged eight years, admitted to Cumberland Street Hospital, October 20th, 1907. "About the 12th, process commenced under left ear and spread down side of neck to chin and appeared like an abscess. There was a temperature, redness and marked constitutional depression. There was no sore throat, no membrane and child could swallow for a week. No earache at any time." Temperature on admission, 104; pulse, 152; respiration, 45. There was an area of swelling from either ear extending downward and forward to the chin and down the left side of the neck to and onto the anterior chest wall as low as the nipples. The swollen area looked like the skin of scarlet fever, but there was no appreciable change in sensation as the examining finger passed from this area to normal tissue. The subcutaneous tissue was œdematous and crepitation was marked over the chest. Expectoration of brownish red fluid which looked like a mixture of pus and blood, difficulty in swallowing. The whole left side of the pharynx and left tonsil were pushed inward. A gangrenous spot had appeared in the integument of the chest wall and ten ounces of fluid similar to that escaping from the mouth was evacuated from the subcutaneous tissue of the chest was through an incision. Temperature varied from 99.6 to 105. Pulse from 120 to 152. Respiration, 30 to 44. She died. Next morning an autopsy showed the following: There was an abscess cavity extending from the skull above, anterior to the sheath of the carotid artery, to the subcutaneous tissues of the chest wall, breaking through the deep fascia just above the sternum, anterior the sterno-mastoid. There was an opening in the left lateral pharyn-

geal wall, high up, close to the skull, between the pterygoid plate and the styloid process. The antrum of Highmore was normal. No fracture of rib or communication with thorax. Dr. Hopke examined a culture of the pus and found the streptococci and the staphylococci pyog. albus. A rabbit was injected with the expectation that the presence of bacillus of malignant cedema or the aerogenes capsulatus might be found, but there was no development of gas or septic phenomena. In my opinion, we did not exclude the presence of either of these two latter germs, as they are grown with difficulty.

As an etiological factor, it might be mentioned that the patient did not have a single sound tooth. Every one was more or less decayed.

THE REPORT OF A FEW REAL CURES OF REAL TUBERCULOSIS.

J. Henry Hallock, M. D., Saranac Lake, N. Y.

With all we hear about tuberculosis nowadays, with its special meetings, its sound advice on contagion, sanitation, new culture products for hypodermic use, etc., etc., how often do we see reports of real cures of real patients? Each writer, of which there are several for every monthly publication coming to my desk, has his own theory, which runs all the way from daily hypodermic injection of some product of the dead germs to the do-nothing method of eat, breathe and wait, of the same food and, perhaps, the same air he has had all his life, only a little more of it.

That some patients improve in spite of remedies used and that some get well is to be expected, but it seems to me that the report of a few cases who actually had tuberculosis and who, under proper treatment, really got well, will make quite as interesting reading as the discovery of a new serum.

The inspiration for this paper came from a discovery I made one day last summer. When at the end of an afternoon office hour I went to my front porch, and there found three patients, all cures, who had met by accident and who had returned from different parts of the country not for treatment, but for a little vacation and to tell me how well they were.

Mrs. W——, sent to me by Dr. F. B. Seitz, of Buffalo, N. Y., and whose description, corresponding with my own examination, I quote verbatim:

"Dr. J. H. Hallock, Saranac Lake, N. Y. Dear Doctor: Will you kindly find accommodation and care for Mrs. N. W., whom we expect to send into the Adirondack region next week.

"She has a history of hæmorrhages eight years ago, now hoarseness for five months, night sweats, afternoon temperature, loss of weight and other symptoms.

"There is also a tubercular infiltration of the vocal chords.

"Dr. Bert. J. Maycock, examining physician, decides she cannot enter Raybrook Sanatorium, as she is too far gone.

"Patient, female; aged thirty; married, has two children. Her father died of consumption."

I will only add from my personal notes that I found infiltration at the apex of both lungs, a beginning tubercular ulcer on right vocal chord. Bacilli in small numbers, and so weak could hardly go upstairs.

I had not seen her since I sent her home, a year and a half before, until she surprised me now.

She assures me that she has not only kept as well as when she left me, but that she never felt better in her life, and while she has been careful she has done a reasonable amount of house work in her home. She is above her usual weight. Has had no cough or other symptoms whatever.

CASE II.—Mr. J. D., sent me by Dr. S. R. Snow, surgeon to the Rochester Homœopathic Hospital, Rochester, N. Y.; Dr. Snow accompanied the patient and his sister to Saranac Lake and went with them to the Raybrook Sanatorium, where he expected patient would be received. This took so much time that he was obliged to start for home without calling on me, but he sent with his patient the following note:

"Dear Dr. Hallock: This will introduce to you Miss D——, who has brought her brother to Saranac Lake for treatment. The case proves to be more advanced than they will accept at Raybrook, so I take pleasure in referring him to you, knowing he will receive good care in your hands."

The following I take from my case book:

Mr. J. D. Draftsman, aged twenty-six, Rochester, N. Y. Has had a cough for about a year. Had been sick in bed one month. At which time he thought he caught cold, for he had a high temperature and felt sick. He had lost weight. Had a cough with ex-

pectoration which contained tubercle bacilli; his appetite was poor and he felt so weak he walked from the street to my office with difficulty.

Examination showed an infiltration at apex of left lung, a considerable amount of consolidation at apex of the right with rales, etc., extending over the entire upper lobe. Temperature, 101. Weight, 148. Mr. D. now weighs 200 pounds, and is working in a coal office, and has been feeling perfectly well for a year, at which time all trace of his former symptoms were gone, and he stopped all treatment and went to work at light work on a farm during the summer. He reported to me lately that he never coughs or has any symptoms of his former trouble and works every day, and I would be glad to give anyone his address who would care to communicate with him. Both these patients are well enough to pass the searching examination of any life insurance company, only for their past history.

CASE III.—Mrs. W——, aged 47, from New York City, had been living for two years in an adjoining town, where, without treatment of any kind, she had hoped to get well.

I first found her in bed with a temperature of 102 and an acute exacerbation of the disease. These had become frequent of late and she had begun to realize that instead of improving as she had hoped she was surely getting worse. Her appetite was poor and the little she did eat distressed her. She was coughing and raising a great deal and felt too sick to care much what happened. Examination showed a typical case of fibroid phthisis; both lungs were bound down with adhesions, and there was scarcely an inch of forced expansion, with rales, etc., extending over nearly the entire upper half of both lungs. The right lung was badly diseased, having a cavity and large amount of consolidation in the upper portion.

She is now living on 93d street, New York City, and Mrs. Hallock, who recently visited her, reports that they went shopping together, and she is enjoying a fair degree of health. She has not felt sick in any way since she returned home last summer. When she left she had gained 90½ to 112 pounds. Had more than twice as much expansion to her chest, could go up and down stairs without any of her former shortness of breath. The cavity had healed and much of the scar tissue had disappeared, but at the late stage of treatment she could not expect to be as entirely well as the two former

patients for it is not possible to restore lost tissue. But I feel she has a chance for a good many years of life and can live comfortably in her room in New York City. I will not report more cases to weary you, but will proceed to tell to what these cures are due.

First I believe Saranac Lake has the best and purest air in the world, with the best all-round surroundings and conditions for the cure of a lung patient.

Next, I believe that Homœopathy offers the best remedies to the doctor who will study his *materia medica*. With remedies, of course, we include the proper diet and this is also a real study, for no two patients are alike.

With the above I have had fair success with consumptive patients for the past twelve years. But three years ago I added a new battery to my force, in the shape of a Chattanooga Vibrator, and a 500 candle power Leucodescent light. At first these were an experiment. I began with the vibrator as an aid to other means, for I had learned by experience of its rapid action upon all the organs of digestion. And through this improved digestion, the rapid making of new blood and building up of the nervous system,—most important factors in all cases of tuberculosis. It was by accident that I discovered the value of the Leucodescent light in curing these cases.

I had been using it for a long time with great success in the cure of all kinds of sores, whether caused by an injury, or of germ origin, and had found cases of blood poison yielding under a few treatments. In 1906 I had referred to me a patient with a tubercular toe. He had been treated by several good surgeons with little relief. They did not operate on account of his lung condition. I treated it as well as I could for a month, when it suddenly grew much worse and I advised his coming to the office for a trial of my light as the only thing I had to offer him. When he came I stopped all other treatment, used the light daily for one month, when the toe was entirely well, and apparently as sound as it ever was. He then suggested that if the light would kill the germs in his toe, and cure it after so many had failed, why wouldn't it do the same in his lungs? I used the light over his lungs for about one month, with great benefit, at which time he left the State and I lost track of him. But I had seen its benefit and decided to follow it up, and have been able to cure with its aid many patients I could not cure otherwise,

one recently of abdominal tuberculosis, usually a rapidly fatal complication. How it acts I cannot say; but it certainly increases the nutrition of the part and so is able to overcome the tubercle bacilli.

It equalizes the circulation and relieves the stasis of the blood vessels, checking inflammatory processes.

The patients above began improvement from the first treatment which was uninterrupted until they were discharged cured.

At some future time I will be glad to give the technique I use in treating these cases, but my paper is already longer than I intended to make it so will close with a few words of advice.

Physicians should remember that tuberculosis is like an unexpected fire; no one can say when it will get beyond control. Early diagnosis and treatment mean success, late treatment may mean failure and defeat.

Sanatoriums are a great boon to humanity, but they are always crowded and with a waiting list, and are certainly not necessary to a recovery. They take only first stage patients and this stage of the disease is so seldom recognized by the general practitioner that but few such ever reach me.

THE DEPARTMENT OF ANATOMY FOR 1910-'11.

Improved Equipment.

The changes in the college building, when completed, improve the anatomy lecture room, as the students will be closer to the lecturer, the width of the room being greater and depth reduced. The large window which formerly permitted light to strike the class in the face is to be eliminated and light admitted at the sides.

The greatest improvement is the Reflectoscope. This is a combined stereopticon and opaque projector. By a turn of a lever the operator may change from one to the other. The Thompson Reflectoscope will be permanently located twenty feet from the screen, and the picture will be seven feet square. As the eye can grasp details so much quicker and so much better than the idea may be conveyed by the human voice, we expect this instrument to be of the greatest assistance to our students. Since the close of the last scholastic year, 500 pictures for opaque projection and about 100 lantern slides of the brain have been secured. We are indebted to Prof. Minton, for a greater part of the lantern slides, and through

his kindness we will have a number of the Lumiere autochrome lantern slides of the brain. Color photography is rather new and requires great care in the making and handling of the plates. The faithful reproduction of the colors of nature repays one for the care and time expended.

His Embryological Models.

Two hundred dollars worth of these celebrated models from the Ziegler laboratory will be delivered about the time College opens. A series of wax models showing the development of the human brain, a series of twelve models showing the development of the human heart, and a series of nine showing the development of the human eye (after Manz) are included in the order. These are made of wax, much enlarged and will be of use in teaching the anatomy of these organs. A study of the development of an organ is absolutely essential to enable the student to understand the anatomy of these complicated structures. Embryology will also explain the malformations and errors in development which are ordinarily not familiar. In addition to the above, an Ayzoux model of the larynx, and two Deyrolle papier mache models, one life size of the spinal cord and sympathetic ganglia and a smaller model representing a short section of the cord, will be added to our present list.

Anatomical Models.

During the past year two models have been made by Prof. Lloyd. One is a model of the pons and medulla, showing in outline, typical cross sections and joined by longitudinal brass wires along the lines of the different fissures. In the interior, placed with accuracy as to size, length and position, are the cranial nerve nuclei, third to twelfth, inclusive, with the nerve fibres represented by fine wires running to the proper point of exit on the surface of the model. The model is ten times natural size. The nerves of exit are colored red for motor and blue for sensory. A person may at a glance tell whether a nerve is motor, sensory or mixed. This model of the complicated nerve structure gives three dimensions, a picture gives but two. The second model represents in series, sections of the spinal cord, cerebellum and medulla, mid-brain and internal capsule. Each section is superposed in order and held by a metal upright. On the upper surface of each section is painted an enlarged reproduction of the microscopical structure it represents. At the proper places are

bored holes through which are strung colored threads to show the course of the various nerve tracts from the lower part of the spinal cord up to the cerebellum and internal capsule, admirably showing the decussation of the motor and sensory tracts in the medulla.

Changes in Our Personnel.

Dr. J. F. White, after a service of nine years in this department, leaves us to enter the department of surgery. As an expression of appreciation during the last term, he was made assistant professor of anatomy. We regret his departure, but are very much pleased to know that the College will still enlist his efforts.

Dr. Mosser will take Dr. White's place and instruct the Freshman class in the osteology of the cranium, arthrology and angiology.

Dr. Lutton, after two years as the Lecturer on Regional Anatomy, will succeed Dr. White as Junior Lecturer on Anatomy, taking osteology (except the head), myology and angiology (veins and lymphatics).

Dr. L. R. Kaufman will have charge of the course in Regional Anatomy.

Dissecting Room.

During the last year, we have had more dissecting material than ever. This was due to the personal effort of the dean. According to present arrangements, we look forward to a continuance of this supply.

The course in Practical Anatomy we consider to be a most important part of a student's medical education. Our men dissect both first and second years. There is a demonstrator always at hand and hasty or careless dissecting is not permitted. We aim to prepare a student for a life work and not merely to pass an examination.

Dr. Fobes, who has been a member of the dissecting room staff for ten years, has become indispensable and will continue as chief demonstrator. Dr. Kaufman is another veteran. Drs. Lutton and Olcott will continue their valued services and Drs. Safford and Halfman have been added to the list of demonstrators.

It is interesting to note that every man in the Department of Anatomy is a graduate of our own beloved alma mater.

We believe records will prove that the teaching in our college is far above the average. We have always been proud of the work of the Anatomical Department; but progress is the order of the day.

FINGER ENUCLEATION OF THE TONSIL.

By Harold A. Foster, M. D., New York City.

The method which I have employed for two years in the removal of tonsils has been *finger enucleation*. Its advantages are that the entire tonsil is removed, the operation is done in less time, with less bleeding and with fewer instruments than by any other method.

For this operation a general anæsthetic is required. After the patient is fully anæsthetised, the mouth-gag is fixed and the assistant supports the head. The operator stands at the patient's right side. He places the tip of the right index finger posterior to the anterior pillar of the right tonsil at its equator. He now directs the pressure *outward* and *forward*, drawing the anterior pillar forward. The pressure is given by the tip of the right index finger. Now proceed with a few strokes, about one-half inch in length, along posterior border of the pillar, and the tip of the finger will be admitted outside the capsule of the tonsil.

In children usually only a slight amount of force is required, while in adults or in children when partial removal has been performed quite a fair amount of force is required. After this point is reached let the distal phalanx sweep upward, outward and backward around the capsule as far as the posterior pillar. The important point thus far has been to direct pressure away from the capsule; now draw the globe forward, peeling it away from the posterior pillar. The precautions to be taken are to keep outside the capsule and not to tear the posterior pillar.

After freeing the tonsil there will remain a small pedicle at its base.

Thus far no sponging is necessary. Now after sponging what blood is in sight, the snare is slipped over the tonsil, and after the volsellum draws it through as far as possible, the snare cuts the pedicle close to the wall of the throat. The left tonsil is now freed by the left index finger following the corresponding direction.

Seventh Avenue and 55th Street.

NOTES ON THE MEDICAL SERVICE AT THE FLOWER HOSPITAL FOR SEPTEMBER, 1910.

By Walter Sands Mills, A. B., M. D., Professor of Medicine, New York Homœopathic Medical College and Flower Hospital,

When I went on duty September 1st in the medical wards of the Flower Hospital I found eighteen patients. During the month forty-nine were admitted. A brief summary follows:

CASE 1.—This was a colored woman, aged 32 years, admitted August 26. The patient was admitted in a state of coma, suffering presumably from gas poisoning and from chronic interstitial nephritis. She died on September 2 without having regained consciousness. When I first saw her, September 1, the patient was unconscious. There was no sign of paralysis. She had a temperature of 104° , higher than at any time before. The pulse was rapid and weak. Respiration slightly increased in frequency but quiet and natural. Catheterization at regular intervals removed from sixteen to twenty-four ounces or more of urine of low specific gravity until the last day or two when the quantity became much less. The death certificate was signed chronic interstitial nephritis. If death was due to inhalation of illuminating gas the case was different from others that I have seen, because usually patients so poisoned either die within a few hours or else recover from the effects of it in a day or two at most. The kidney condition was certain, and the death was, therefore, attributed to it. Hot packs, stimulation, medication, none of these measures had any effect in causing consciousness to return.

CASE 2.—This was a man aged 35 years. He was brought in in the ambulance on September 2, and died two hours after admission. The man had acute dilatation of the heart and died of heart failure.

CASE 3.—This was a girl aged 19 years. She entered the hospital August 26, and left cured September 3. She had a light attack of dry pleurisy.

CASE 4.—This was a boy aged 13 years. He entered the hospital July 28, and was dismissed cured on September 4. He had typhoid fever.

CASE 5.—This was a man aged 45 years. He entered the hospital July 31, and was dismissed cured on September 4. He had typhoid fever.

CASE 6.—This was a colored man aged 50 years. He entered the hospital August 23, and was discharged cured September 4. He had pleurisy and pneumonia.

CASE 7.—This was a woman aged 45 years. She was admitted August 28, unconscious from accidentally inhaling illuminating gas. Under stimulation, high enemas and packs she regained consciousness in twelve hours. From then on she made an uninterrupted recovery. She was dismissed cured on September 4. The urine, normal in quantity, continued of low specific gravity.

CASE 8.—A woman aged 40 years. This patient was demented. She was admitted August 31. Her family took her away on September 5.

CASE 9.—A woman aged 26. This woman was also crazy. She was brought in in the ambulance on September 5, and after a few hours removed to the psychopathic ward at Bellevue.

CASE 10.—Man aged 32 years. This is the same patient recorded as case 45 in my March service, as published in the *CHIRONIAN* for May. This patient had acute articular rheumatism eight years ago. He was left with heart and kidneys diseased. Each winter since he has been laid up with dropsy. He was in the hospital from December 24, 1909, to February 3, 1910, from February 16 to June 3, and was brought back in bad shape again on July 30. When I went on duty again, September 1, the patient had general cedema. He failed to respond to treatment and died September 5.

CASE 11.—Boy aged 10 years. This patient entered the hospital July 30 with typhoid fever. He was discharged cured September 5.

CASE 12.—Man aged 51 years. Patient had had vomiting and diarrhoea for a week. Ipecac followed by arsenic cured him. He left the hospital September 6.

CASE 13.—Man aged 30 years. This was a case of heat prostration. The patient was unconscious when brought in, and had a temperature of 110°. The temperature was reduced by playing the hose on him and the heart was stimulated. He lived from 8 P. M., September 5, till 3 P. M., September 6. He never regained consciousness.

CASE 14.—Man aged 27 years. This patient entered the hospital July 26 with typhoid fever. He was dismissed cured on September 7.

CASE 15.—Man aged 40 years. This patient was admitted September 2, with pneumonia and typhoid fever. He was in very

serious condition when admitted. Was delirious and never was rational. He died September 7.

CASE 16.—Man aged 41 years. This patient was found unconscious from gas on September 7. Oxygen was administered. High enemas given. The patient recovered promptly and was dismissed cured September 8.

CASE 17.—Man aged 46, admitted September 4. Patient had a slight temperature, a grippy cold. Dismissed cured September 8.

CASE 18.—This patient entered the hospital September 3. Man aged 32. Had pain in left groin. Pulse slow. He had had malaria several times. The pain left and patient was dismissed in good condition September 9.

CASE 19.—Woman aged 29 years. This patient was an epileptic. She entered of her own accord on September 8. Had two or three seizures while there, and left on her own accord on September 9.

CASE 20.—Woman aged 30 years. This patient fainted on the street on the evening of September 8. As she did not recover consciousness promptly an ambulance call was sent in and she was removed to the hospital. She regained consciousness a few hours later and went home September 9.

CASE 21.—Man aged 23 years. Entered the hospital August 24 with gonorrhœal rheumatism. When I went on duty September 1 patient was still running a temperature of 110° or so. He was very anæmic. Liver was enlarged. There was also an endocarditis with a mitral regurgitant murmur at apex and extending up to pulmonary area. The remedy given was bryonia. He had also had aspirin. During the next few days the pain in his leg disappeared, although the temperature kept up. On the night of September 8 patient had a slight chill, with a rise of temperature to 104.2° at 4 A. M. the next morning. From then on the temperature gradually went down till it reached normal on the morning of the 10th. On making my daily visit at about eleven that morning patient complained of a little nausea, but otherwise seemed about the same. A few minutes later, while I was examining another patient, this man suddenly gave a few gasps and was dead.

CASE 22.—Woman aged 28 years. Admitted August 29. Patient had tonsillitis, the temperature going as high as 103° . By September 3 it had become normal. Patient was dismissed cured September 10.

CASE 23.—Girl aged 17 years. Admitted to hospital September 6, from ambulance. This patient is subject to fainting attacks. She had several after entering the hospital. She left in good condition September 10.

CASE 24.—Infant, aged 6 weeks, was admitted to the hospital with an infected circumcision. Whoever had operated had made a botch of the job. The prepuce had evidently been drawn forward and the redundant portion cut off. There the operation had stopped. The skin had retracted. The portion of the foreskin adherent to the glans had never been freed from the glans and was still in situ. There was no evidence whatever that any effort had been made to retract it. No stitches had been inserted. The site of the wound was pussy, the penis and scrotum œdematous and red. I was asked to see the case September 6, to say whether or no the infant had erysipelas. The temperature was 104°. The general condition of the child was remarkably good. The skin condition was not erysipelas but a simple œdema and erythema like that often found surrounding infected wounds of the skin or mucous membranes. The erythema gradually extended up the abdomen and down the legs during two or three days, as a sort of irregular ring, fading from the parts nearest the wound as it advanced at the periphery. As soon as antiseptic treatment was made to the wound itself the temperature began to come down. The swelling and redness of the skin were gone by September 10.

CASE 25.—Boy aged 9 years. This patient entered the hospital September 5. He gave a history of having in play been thrown into an iron watering trough on August 31. His right shoulder had been injured. We could find no evidence of fracture or dislocation, although shoulder and arm both became swollen and tender. A radiograph failed to show any abnormality. He had a temperature of 103, rapid respirations and increased pulse rate. A diagnosis was made of pneumonia, although physical signs did not develop till the 7th. It was central at first and then extended to the surface. He was given ferrum phosphoricum till the 8th. Then he had bryonia, and on the 9th hyoscyamus. He got gradually worse, becoming unconscious on the 9th and remaining so until he died on September 11th.

CASE 26.—Man aged 25 years. Admitted to hospital September 4 with rheumatism. Not very ill. Dismissed cured September 10.

CASE 27.—Woman aged 32 years. This patient was admitted to the hospital July 28, suffering from typhoid fever. During the decline of the disease she developed several boils. She was dismissed cured September 11.

CASE 28.—Man aged 35 years. Patient entered the hospital September 9, suffering from pleuritic effusion, right side of chest. He had been tapped five times at other institutions. He left the hospital at his own request September 11 without special treatment.

CASE 29.—Woman aged 30 years. This patient entered the hospital September 7, suffering from typhoid fever. She was in a serious condition when she entered. She had been badly cared for and was not clean. She was delirious when she entered and never became rational. On the 10th pneumonia was added to the picture, and on the 12th patient died.

CASE 30.—Man aged 44 years. This patient was seized with unconsciousness in a subway train on September 2. He was in a state of collapse on reaching the hospital. Stimulants and heat were applied, and after an hour or two he recovered consciousness. The heart was rapid, weak, and the sounds ill-defined. A day or two later an aortic murmur became evident with the first sound. Patient ran a temperature of about 100° during his stay in the hospital. He was taken home September 12.

CASE 31.—Woman aged 35 years. Patient was admitted September 6 with pneumonia of right lower lobe. By September 9 the left lower lobe had become affected. The upper part of the right then became involved. Part of the time—September 10 to the end—the respiration ranged from 60 to 70 per minute. The temperature for the first two or three days was like an intermittent fever, ranging from 98° to 103° each day. It never got very high. The variations were not so great toward the end. On the evening of the 12th it was 98.6° , pulse good, respiration 70. Patient died on the morning of the 13th.

CASE 32.—Woman aged 22 years. Admitted to the hospital August 5. Patient seemed a little deficient, mentally. She could not speak English. As near as could be gathered from her friends she had had an occasional fit. None were noted during her stay at the hospital. Her friends took her away September 15.

CASE 33.—Woman aged 24 years. This patient had a baby aged five months at home. Later she had a mastitis in the right breast,

which had been opened and had healed. She entered the hospital September 2 with acute articular rheumatism of two weeks' standing. She had a slight mitral murmur. She was given bryonia. Patient was dismissed cured September 15.

CASE 34.—Man admitted August 8, aged 20 years. This patient had typhoid fever. The disease ran a typical course, and the patient was dismissed cured September 16.

CASE 35.—Man aged 26. This patient was admitted September 14 suffering from alcoholism. He was discharged September 16.

CASE 36.—Boy aged 16 years. This patient entered the hospital August 13 suffering from typhoid fever. His temperature became normal first on September 2. His diet consisted of broths and milk; his remedy was bryonia. The patient was dismissed cured September 20.

CASE 37.—Man aged 23 years. Patient was brought in suffering from syncope September 19. He gave a history of having given his blood by transfusion to an injured friend the day before. The operation was performed at another hospital. Against the advice of the physicians in charge he tried to go home and collapsed on the street. He left the Flower Hospital September 20.

CASE 38.—Girl aged 16 years. This patient was admitted September 14. She had a bad endocarditis, and later developed pneumonia, starting in the left upper lobe. She died September 21.

CASE 39.—Girl aged 10 years. Patient entered the hospital with slight temperature and malaise September 17. She had aphthous stomatitis—round white spots on the lower lip at first, then some on the cheeks. They rapidly turned a dirty yellow and slowly disappeared. The spots were tender. The tongue was also coated. Patient's mother took her home September 22 nearly well.

CASE 40.—Woman aged 30 years. Acute gastritis. Admitted September 14, dismissed cured September 22, 1910.

CASE 41.—Boy aged 12 years. Admitted August 4 suffering from typhoid fever. This patient had been on a water diet. When I went on service September 1 I found him very much emaciated. He was still running a temperature, but eggs and toast were added to the diet notwithstanding. By the 8th the temperature was normal. This patient developed a number of boils during his illness. He was dismissed cured September 24.

I would like to say in passing that I do not believe in the water

diet in typhoid fever. I do believe in a comparatively liberal diet. I allow milk, weak coffee for those accustomed to coffee, soft boiled eggs, milk toast, broths, gruels, jellies, ice cream, orange juice, ripe bananas throughout the disease. With a bill of fare like this to draw from the meals can be varied and the patient go through his illness in comfort and with comparatively little wasting away. Moreover, I believe the disease runs a milder course with a liberal diet because the patient has a better nourished body to fight with.

CASE 42.—Man aged 26 years. This was the same man as Case 35. He came back September 21 still suffering from the same attack of alcoholism, and left September 24.

CASE 43.—Man aged 50 years. Patient was admitted September 24 suffering from hæmorrhage, probably of the stomach. He died in a very few hours. Autopsy refused.

CASE 44.—Man aged 43 years. Admitted September 22, suffering from pneumonia and delirium tremens, pediculosis and general neglect. Patient died September 25.

CASE 45.—Man aged 58 years. Taken ill on the street with acute indigestion, September 25. Left hospital September 26.

CASE 46.—Man aged 40 years. Entered the hospital September 8 with catarrhal jaundice. Patient had a previous attack in May. This attack cleared up under bryonia. Patient was dismissed September 26.

CASE 47.—Man aged 65 years. This patient had locomotor ataxia and was turned over to the neurologist. He was admitted September 20.

CASE 48.—Man aged 24. Admitted September 26 with dry pleurisy. Discharged September 30.

CASE 49.—Man aged 26. Admitted September 29 suffering from rheumatism. Patient left the hospital October 1.

There remained in the hospital when I went off service:

CASE 50.—Woman aged 67 years. She had a slight skin lesion on one side of the face. She was admitted September 2.

CASE 51.—Man aged 39 years. Patient admitted September 3 suffering from acute articular rheumatism. He had been ill about a week. It was in his arms first, then his feet. It then localized itself in the right hand and left foot. The temperature ranged from 98° to 100°, the pulse about 100.

CASE 52.—Man aged 61 years, admitted September 6. The pa-

tient had general œdema and asthma due primarily to an aortic regurgitation. Patient was unable at any time to lie down on account of the dyspnœa. For a week this patient had apis, then the remedy was changed to apocynum. He was gradually improving at the end of the month.

CASE 53.—Man aged 35 years, admitted September 7. This patient had a mitral lesion. He had cedema, not quite so marked as the preceding case, and he could lie down. He was in fairly good condition at the end of the month. He had apis throughout.

CASE 54.—Man aged 26 years, admitted September 14, suffering from acute articular rheumatism. The patient was discharged from the Presbyterian Hospital where he had had typhoid fever only one week before. The pains were severe and the sweating profuse. He was given bryonia as a remedy, and, in addition, eight ounces of water every hour from 8 A. M. to 6 P. M. The water flushes the system, thereby lessening the pains, and sweating becomes less profuse and less acrid.

CASE 55.—Woman aged 37 years, admitted September 17. This patient was a nuerasthenic, and was transferred to Dr. Wilson's service.

CASE 56.—Man aged 26 years, admitted September 20. After running an irregular fever for several days this patient developed a typical chill, fever and sweat every thirty-six hours. Quinine stopped it.

CASE 57.—Man aged 29 years, admitted September 21. This patient had vomiting every day. He had a slow pulse and no fever. There was pain and tenderness over the epigastrium. The diagnosis was still in doubt when I went off service. It seemed to me like a gall bladder condition.

CASE 58.—Man aged 19, admitted September 23. This was a case of typhoid fever. The temperature ranged about 104°. On the 30th the temperature dropped from 106° to 98° in a few hours. During that time the pulse was good, the patient felt good but was in a profuse perspiration. The temperature ran up again October 1, but not so high, and finally resumed the normal.

CASE 59.—Man aged 28, admitted September 24. This patient had typhoid fever.

CASE 60.—Man aged 35, admitted September 24. This patient had chronic nephritis, a weak heart with failing compensation and

general œdema. For a day or two he seemed to be on the verge of uremic coma; he was stupid and at times delirious. Apis helped him, and in a few days he was sitting up.

CASE 61.—Woman aged 38, admitted September 24. This patient had typhoid fever.

CASE 62.—Man aged 50, admitted September 25. This patient had pleurisy with effusion.

CASE 63.—Woman aged 31, admitted September 26, suffering from acute articular rheumatism.

CASE 64.—Woman aged 44, admitted September 26. Neurasthenia.

CASE 65.—Woman aged 38, admitted September 27. Intermittent fever with paroxysms every day.

CASE 66.—Man aged 24, admitted September 29. Hysteria.

CASE 67.—Man aged 30, admitted September 30. Typhoid fever.

REMARKS.

Of the 67 cases recorded, 14 were cases of typhoid fever, a large percentage it seems to me. I had but two cases of typhoid in my March service of 63 patients. In September there were six cases of pneumonia and six cases of rheumatism, as compared with fifteen and sixteen in March. The other cases require no special mention.

EDITORIAL

DR. HARRISON GREENLEAF SLOAT.

With the September number of the *CHIRONIAN* Dr. Harrison Greenleaf Sloat finished his editorship. He has taken up other work in connection with the college. During Dr. Sloat's administration the journal attained a high plane of excellency, which it will be the aim of the new editors to keep up, and, if possible, improve upon.

THE CHIRONIAN.

With this number the *CHIRONIAN* begins a new administration of its affairs. It will be the effort of the editors to make it the medium through which the alumni shall be kept informed of the affairs of the New York Homœopathic Medical College and Flower Hospital. It will also be their endeavor to keep the alumni in various places informed as to the doings of their fellow alumni. This will require active co-operation on the part of all, and every member of the family of our Alma Mater is requested to report items of general interest.

Special attention is called to the article in this number describing the anatomical department. Anatomy is one of the fundamentals of a medical education. Nowhere are the facilities for its teaching any greater than at the New York Homœopathic Medical College and Flower Hospital.

The November number will have an article on the physiological department.

CHRISTIAN SCIENCE AND HOMŒOPATHY.

The *Post-Graduate*, a monthly journal issued by the New York Post-Graduate Medical School and Hospital, has some editorial comments on Christian Science in its September number. The editor is Dr. Henry T. Brooks, the pathologist. Dr. Brooks evidently thinks Christian Science is on the decline, and his editorial, after discussing that phase of the subject, says:

"Christian Science has not deprived the regular medical profession of much of its clientele, but it has been hard upon the Homœopath-

ists, a large part of whose practice was with the idle class of wealthy people who wish to have a great deal of medical attention without being obliged to take things which taste badly. There are a great many people who enjoy being comfortably ill, and who enjoy the sympathy of friends and relatives—and of the parson—and who at the same time dislike very much to take pills of a color which does not harmonize with that of their hair ribbons. Christian Science went a step further than Homœopathy by not even requiring the taking of any doses at all at frequent intervals, and by making the dose, when it had to be taken, one that seemed to be in accord with the intellectual powers.”

Comment on the above seems hardly necessary. Yet it is worth while to make a note of it, as it is published in a journal that is the official organ of an institution that reaches out for—and has received many—Homœopathic students.

A NEW TRUSTEE.

Rev. Dr. John Haynes Holmes, minister of the Church of the Messiah, has been elected a member of the Board of Trustees of the New York Homœopathic Medical College and Flower Hospital, vice Dean Copeland, resigned. The dean resigned because of a provision in the city charter that no charitable institution shall receive money from the city if any member of its Board of Trustees is a salaried official. With Dean Copeland's resignation as a trustee, the board still has his services as dean. With the Rev. Dr. Holmes' election to the board, it has added to it an active and enthusiastic worker and an ardent Homœopath.

A NEW SUPERINTENDENT OF THE TRAINING SCHOOL.

On September first, Miss Marion Elizabeth Seaver became the head of the Flower Hospital Training School. Miss Seaver is a graduate of the New York Post-Graduate Training School. Since leaving there she has had service at the Smith Infirmary, on Staten Island, and at Oswego, New York. She came to the Flower from the latter place, where she had made such a fine record that the authorities did not want her to leave.

A NEW MOTOR AMBULANCE.

One day in August a woman, suffering from the heat, was brought into the Flower Hospital in an ambulance. She remained as a patient for twenty-four hours. When she left she expressed her satisfaction at the care and attention she had received. Unknown to the hospital doctors and nurses, they had entertained an angel unawares. A few days later the patient returned with a great bunch of American Beauty roses and asked to be shown through the hospital. She seemed interested in what she saw, distributed the roses, asked many questions about the institution, and said she would be glad to come again. Early in September she came again, and a little later a new Cadillac motor ambulance drove into the courtyard and was presented by her to the hospital. She has requested that her name be withheld from publication.

WORK AT THE FLOWER HOSPITAL FOR THE MONTH OF SEPTEMBER, 1910

Number of ambulance calls	543
Number of patients treated in the emergency room	579
Number of surgical cases admitted to the hospital	212
Number of medical cases admitted	96
Number of maternity cases	7
Number of cases treated in the out-patient department	3455

DR. BRET NOTTINGHAM, '01

Dr. Nottingham has been appointed a member of the Michigan Board of Registration and Medicine in place of Dr. Joseph H. Ball, who resigned to become professor of bacteriology at the New York Homœopathic Medical College and Flower Hospital. This board corresponds to the New York State Board of Regents. Dr. Nottingham has been in practice in Lansing, Michigan, ever since his graduation.

THE ALUMNI OF THE CUMBERLAND STREET HOSPITAL,

Brooklyn, will hold its annual dinner on the evening of Friday, November 4, 1910, at the Hotel Clarendon in Brooklyn. It is expected that there will be a large attendance. These dinners are among the most successful of the homœopathic dinners, and the speaking is always good.

ALUMNI OF THE METROPOLITAN HOSPITAL.

The Alumni of the Metropolitan Hospital will hold their annual dinner December 7, 1910.

A Department of Physical Therapeutics was established in the New York Homœopathic Medical College and Flower Hospital in 1902. Now comes the announcement in the *New York Medical Journal* that Temple University, in Philadelphia, is about to establish such a department, and that it is "the first instance of such a department being established in a medical school."

Mayor Gaynor, recovered from the attack on his life, is to resume his work as mayor early in October.

Cholera is knocking at the doors of this country. It behooves the Federal and State officials to be most vigilant in watching all incomers at the various ports of entry.

ALUMNI NOTES.

To the Alumni: Books for the Library needed. Many of our graduates possess antique text-books of Anatomy, Surgery and Obstetrics, which are the more valuable because of the finely engraved plates. Our predecessors may not have had a knowledge of the finer anatomy of the human body, but they knew how to make paper that would last and engraved plates which commanded respect and admiration. How much richer our College Library would be if some of our men would occasionally remember the college. Modern text-books are welcome or money, which may be turned into text-books. Our Museum is not to be forgotten. Should any one obtain specimens of interest and rarity, such as congenital malformed hearts, monstrosities, cervical ribs, etc., do not forget the College "pays the freight." Acknowledgment of any gift will be made in these columns and in the book or upon the specimen container, as the case may be. Should you have a specimen to send, communicate with the Professor of Anatomy, Dr. Lloyd, who will forward instructions and see that the specimen is cared for upon arrival. Let us all bear the College in mind.

Dr. Walter Sands Mills, '89, has been appointed a medical examiner for the New York State Hospital for Incipient Pulmonary Tuberculosis at Ray Brook. The other New York City examiner representing the Homœopathic school is Dr. George F. Laidlaw, '90.

Dr. William Henry Tallmadge, Jr., '04, announces his removal to 537 Riverside Drive, N. Y. City. Office hours: 9-11 A. M.; 7-9 P. M. Telephone, Morningside 3409.

Dr. Frederick W. Smith, '77, died at Niantic, Conn., September 24, 1910. Dr. Smith practiced in New London for twenty-five years.

Invitations are out for the wedding of Dr. Harold Alfred Foster, '05, to Miss Constance Ives, of Montclair, New Jersey, on October 18. Dr. Foster will return to his office November 5.

Dr. Frank E. Smith, '04, desires to announce that, commencing September 22d, his office will be at 155 West 48th Street (one door east of the old address). Office hours as usual—11 A. M. to 1 P. M., 5 to 7 P. M. Telephone as before, Bryant 4597.

Dr. Bukk G. Carleton, '76, resumed his usual office hours September fifth. Dr. Sprague Carleton, '06, returned September twenty-eighth. Beginning October first, special afternoon appointments can be arranged for cystoscopic, urethro and uretro-cystoscopic examinations; intra-vesical, ureteral and kidney treatments. 75 West 50th Street, New York City. Telephone, 117 Plaza.

Dr. Harrison Greenleaf Sloat, '01, announces his removal to 145 West Ninety-fifth Street. Hours: 8 to 10 A. M., 7 to 8 P. M. Phone 3776 Riverside.

Dr. Wm. H. Van Den Burg, '87, has returned to the city and from this date can be consulted as usual. Patients will not be seen in the office on Sundays except by appointment. Hours: 9 A. M. to 12 M. and by appointment. 30 West 48th Street, New York.

Dr. C. W. Datesman, '03, has disposed of his practice at Oradell, New Jersey, to Dr. Chester A. King, '07. Dr. Datesman goes to Colorado Springs to locate, on account of his health.

Dr. R. S. Copeland, dean, announces that his telephone number has been changed to 4262 Columbus.

Lt. J. W. Stillwell, U. S. A., son of Dr. B. W. Stillwell, '87, will be married to Miss Winifred Alison Smith, of Syracuse, October 18.

Dr. L. M. Stanton has removed from 152 West 57th street to 207 West 56th street, New York. Telephone, 4213 Columbus.

Dr. E. W. Kellog, '03, has removed to the Wyoming Apartments, Seventh avenue and 55th street, New York.

Dr. Otis Jameson Case, Class of 1907, New York Homœopathic Medical College and Flower Hospital, desires to announce that having completed his course as interne in the Flower Hospital, New York, and also resident surgeon in the National Homœopathic Hospital, Washington, D. C., he has returned from his post-graduate study abroad, following his resignation as assistant surgeon of the U. S. S. Gedney, and has opened an office at 932 Elmwood avenue, Buffalo, New York, giving special attention to surgery, gynæcology and obstetrics.

Dr. John Arschagouni has returned to Turkey and opened an office in Constantinople. Dr. Arschagouni graduated at Hahne-mann in Philadelphia in 1891. He served as interne at the old Ward's Island Hospital from May 1, 1891, till May 1, 1892. Later he was at the Five Points House of Industry. He practiced in New York until 1910.

Dr. Haskell S. Phelps, '10, announces the removal of his office and residence to 114 West Thirteenth street, New York. Office hours, 8 to 10 A. M., 5 to 6 P. M. Sundays, 9 to 11 A. M. Telephone, Chelsea 2238.

Dr. Wallace B. House, '99, has removed to 135 West 78th street, New York. Office hours, 9-11, 5-7, Sundays until 11 A. M.

Dr. Howard P. Gates, '95, formerly of San Jose, after a trip through Brazil, expects to locate in Los Angeles, Cal. Dr. Gates visited New York in October.

Dr. H. P. Cole, '72; Dr. W. G. Crump, '95, and Dr. J. F. Rankin, '01, of Brooklyn, after the great Institute meeting at Los Angeles, made a trip to Alaska, returning by way of Washington State, the Canadian Rockies, Yellowstone Park, and the great lakes.

Dr. William Harvey King, '82, has removed to 40 East 41st street, New York City. Office hours, 9-12. Telephone, 6950 Murray Hill.

Dr. William Francis Honan desires to announce his removal to 15 West 73d street. Office hours, 11 to 12:30. Sunday by appointment only. Telephone, 5867 Columbus. Surgery and gynæcology.